OEMS FORM
Rev. 09/21/07

Office of Emergency Medical Services

APPLICATION FOR ACCREDITATION RENEWAL

Section I

Start date	End date

Date application received by OEMS

Please print and complete all requested information.

1. APPLICANT STATUS:

☐ **First Time Accreditation Renewal** ☐ **Substantially Equivalent Accreditation Renewal**

2. **CONTACT INFORMATION:**

a. Official name and mailing address for the applicant training institution.

_____
Name of Institution

_____ _____
Address Number/PO Box Street name

_____ _____ _____
City/Town State Zip Code

Telephone # ( ) __ __ __ -__ __ __ __ FAX # ( ) __ __ __ -__ __ __ __

_____
Institution Web Address

b. Official representative for the institution, and the EMS program operation/administration, who prepared application responses. This person will serve as the official liaison between the institution, and OEMS.

_____ _____ _____
First Name Middle Initial Last Name

_____
Official Title

Telephone # ( ) __ __ __ -__ __ __ __ FAX # ( ) __ __ __ -__ __ __ __ e-mail _____

3. **LEVEL OF EMS TRAINING INSTITUTION PROVIDES:** Please check appropriate box or boxes

Initial EMT Training (Curriculum/Minimum Hrs.)	**Refresher Training**	**Continuing Education**
☐ EMT-Basic (DOT 1994 110 Hr. Minimum)	☐ EMT-Basic Refresher	☐ EMT-Basic
☐ EMT-Intermediate (DOT 1985 250 Hr. Minimum)	☐ EMT-Intermediate	☐ EMT-Intermediate
☐ EMT-Paramedic (DOT 1998 1050 Hr. Minimum)	☐ EMT-Paramedic	☐ EMT-Paramedic

4. **TYPE OF INSTITUTION:(*Check appropriate box, and circle appropriate title)***

a) ☐ Four-year College/University
b) ☐ 2 Year Technical or Community College
c) ☐ Hospital/Medical Center
d) ☐ Vocational/Technical School/High School
e) ☐ United States Military (DOD Army, Navy, Air Force, and Coast Guard)
f) ☐ State, county, or local government
g) ☐ Other public or private entities that meet State & local business license requirements

_____

5. **EMS TRAINING INSTITUTION PERSONNEL:**

a) Medical Director:

_____ _____ _____
First Name Middle Initial Last Name
Telephone # ( ) __ __ __ -__ __ __ __ FAX # ( ) __ __ __ -__ __ __ __
E-mail _____
Massachusetts Medical License Number: _____

b) Director/Coordinator:

_____ _____ _____
First Name Middle Initial Last Name
Telephone # ( ) __ __ __ -__ __ __ __ FAX # ( ) __ __ __ -__ __ __ __
E-mail _____

c) Clinical Coordinator (where applicable):

_____ _____ _____
First Name Middle Initial Last Name
Telephone # ( ) __ __ __ -__ __ __ __ FAX # ( ) __ __ __ -__ __ __ __
E-mail _____
Massachusetts EMT Certification # and/or Nurse License #: _____

d) Field Internship Coordinator (where applicable):

_____ _____ _____
First Name Middle Initial Last Name
Telephone # ( ) __ __ __ -__ __ __ __ FAX # ( ) __ __ __ -__ __ __ __
E-mail _____
Massachusetts EMT Certification # and/or Nurse License #: _____

e) Attach a list of all current instructors (I/Cs) along with their EMT numbers

6. **FACILITIES:**

a) Location (actual location of **all** didactic & lab training, if more than one location provide on separate sheet)

_____
Name of facility and/or building(s)

_____ _____
Address or building # Street name

_____ _____ _____
City/Town State Zip Code

b) Facility's Student Capacity (didactic & lab training) if more than one campus attach for each location

☐ 10-20 ☐ 20-30 ☐ 30-40 ☐ 40-50 ☐ greater than 50 Provide # _____

7. **ALS CLINICAL INTERNSHIP SITES AND RESOURCE SUMMARY:**

List all clinical sites affiliated with training institution. Provide an expiration date for each affiliation agreement and list the number of students that will be allowed in each medical specialty area. If a class has thirty students, clinical sites collectively must support 30 students.

	Hospital Name	Expire. Date	ED	OR	ICU	PSYC	L&D	IV	PEDI	Other
sample	XYZ Hospital	01/01/10	20	10	20	none	15	20	20	
sample	All Care Hospital	07/30/10	10	20	10	30	15	10	10	
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2.										
3.										
4.										
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11.										
12.										

8. **ALS FIELD INTERNSHIP SITES AND STUDENT RESOURCE SUMMARY:**

List all field internship sites affiliated with training institution. Provide an expiration date for each field affiliation agreement. The field internship resources must be able to collectively support the skill requirements for your students. If class has thirty students, field sites collectively must be able to support 30 students.

	Service Name	Initiation Date for Agreement	Expiration Date for Agreement	Min # Students	Max # Students	ALS Survey
Sample	XYZ Ambulance Service	December 31, 2008	December 31, 2010	5	10	Yes
Sample	P-Medic Transport, Inc.	December 31, 2008	December 31, 2010	15	25	Yes
1.						
2.						
3.						
4.						
5.						
6.						
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10.						
11.						
12.						

9. **BACKGROUND:**

(a) Does the applicant have a training compliance history in any other state or jurisdictions?
☐ Yes ☐ No (If **yes** attach an explanation, and or supporting documentation.)

(b) Have you, or any of your faculty, ever been convicted of any misdemeanor or felony under the laws of Massachusetts or any other state, the United States, or a foreign country (including a guilty plea or *nolo contendere* plea)? (If **yes** attach an explanation, and or supporting documentation.)

1. Medical director ☐ Yes ☐ No
2. Program director ☐ Yes ☐ No
3. Clinical coordinator ☐ Yes ☐ No
4. Field internship coordinator ☐ Yes ☐ No
5. Didactic instructor/coordinator (s) ☐ Yes ☐ No
6. Adjunct faculty ☐ Yes ☐ No

(c) Within the past three-years have you, or any of your faculty, engaged in the use of illegal drugs or the misuse of prescription drugs? (If **yes** attach an explanation, and or supporting documentation.)
☐ Yes ☐ No

10. **AFFIRMATIONS:**

(a) ☐ Attest to applicant training institution's legal capacity to operate. (Attach supporting documentation, including copies of articles of incorporation and corporate by-laws).

(b) ☐ The applicant training institution hereby affirms that they comply with, and will continue to comply with, all relevant federal and state laws, including but not limited to, federal and state anti-discrimination statutes, M.G.L. c. 111C; regulations, including but not limited to 105 CMR 170.000 and 105 CMR 700.000, and the Department's Administrative Requirements, the Statewide Treatment Protocols, policies and advisories.

(c) ☐ The applicant training institution hereby affirms it meets eligibility requirements for accreditation pursuant to 105 CMR 170.946, and that it can and will fulfill the duties and obligations of accredited training institutions pursuant to 105 CMR 170.950, which includes the duty to administer the Massachusetts EMT practical examination requirements, in accordance with Administrative Requirement (A/R) 2-214.

(d) ☐ The training institution hereby affirms that the most current Massachusetts EMS Statewide Treatment Protocols are taught as part of the training curriculum.

(e) ☐ The training institution hereby affirms that they comply with all NHTSA/DOT EMS standards, as implemented by the Department.

(f) ☐ The training institution hereby affirms that if any of the application information changes, the institution will notify OEMS immediate.

NOTE: *The individual whose name appears below is the official representative of the EMS training institution, and must have legal authority to sign all of the necessary program documents and to make legally binding contracts.*

I _____ _____ _____
(Print Name) (Title) (Signature)
hereby affirms that all information provided to DPH/OEMS in the application packets sections I and II is up-to-date and accurate. _____
(Date)